American Diabetes Association.

Statement

of

Alan Altschuler

Chairman

of the

American Diabetes Association

before the

House Commerce
Subcommittee On Health and the Environment

Regarding

Medicare Preventive and Quality Standards

Friday, April 11, 1997

Thank you for the opportunity to address the House Commerce Committee today on behalf of the American Diabetes Association. I am delighted to be here. I would like to extend a special thank you to Chairman Bilirakis and Congresswoman Furse for their dedication and commitment to diabetes.

Chairman Bilirakis and members of the subcommittee, I am Alan Altchuler, Chairman of the Board of the American Diabetes Association. I would like to share our views on HR 15, the Medicare Preventive Benefit Improvement Act of 1997. We appreciate your leadership on this very important issue of advancing preventive care for improved health and a better quality of life for seniors while reducing long-term health expenses for our nation. Reducing the economic burden wrought by diabetes is essential to Medicare's long-term viability.

First, let me share with you who we are. The American Diabetes Association is the nation's leading nonprofit health organization dedicated to the prevention and cure of diabetes. Our mission is not only to prevent and cure diabetes, but also to improve the lives of all people affected by diabetes. Founded in 1940, today we have affiliates and chapters in more than 800 communities who conduct programs in all 50 states and the District of Columbia.

The ADA funds research, publishes scientific findings, and provides information and other services to people with diabetes, their families, health care professionals and the public. In addition, during the past two years, we have turned our attention to being the strongest possible advocate for people with diabetes. The moving force behind our work is a network of more than two million volunteers, including a membership of 280,000 diabetes patients and their families, and a professional society of more than 13,000 physicians, scientists, nurses, dietitians, pharmacists, social workers and educators.

Mr. Chairman, the American Diabetes Association truly appreciates the fact that you have joined in leading the effort on behalf of improving diabetes coverage in the Medicare program. HR 15, can contribute significantly toward resolving one of the biggest problems currently facing our nation today: ensuring adequate medical care for our seniors in the years to come. Virtually any news report these days refers to the upcoming dilemma of providing coverage to the baby-boomers as they face retirement in the very near future. Our nation needs to find ways of providing more coverage for less cost; we need to maximize our national healthcare resources, and soon.

That is why diabetes is a significant issue. According to the National Institutes for Health, diabetes is responsible for 1 in every 7 national health care dollars spent, consuming nearly $138 billion annually. However, there is a way to save the system money while simultaneously improving coverage and health. Because of many studies in the field, we know money can be saved by providing comprehensive coverage of diabetes outpatient self-management training and supplies.

On July 27, 1994, Speaker Gingrich stated on Good Morning America that

> [W]e don't today pay for training you, as a diabetic, how to take care of yourself. We will pay to put you in the hospital [and to] amputate your leg when you fail to take care of yourself. But literally, the government bias today is to not pay for the preventive and educational experience that will lower your costs.

The American Diabetes Association wholeheartedly agrees with Speaker Gingrich in this matter. As the American Diabetes Association's Chair, I am here today to applaud the Speaker's, and Congress' efforts to begin to remove that "government bias" and improve coverage of diabetes-related supplies and education while simultaneously saving the U.S. Treasury billions of dollars.

When HR 15 was introduced Representative Thomas, Chair of the House Ways and Means subcommittee on Health said:

> Without dedication or proper treatment, diabetes can lead to kidney failure, amputation, nerve damage, blindness, extended hospitalizations, heart disease, and strokes....These medical complications and resulting costs are often avoidable through patient education on proper nutrition, exercise, blood sugar monitoring, activity and medication so that patients can take charge of their wellness. We not only empower people to take back control of their health care through patient self-management training, but we ease the financial burden by including blood-testing strips as durable medical equipment for the purposes of Medicare coverage.

and Mr. Chairman, you have said "diabetes [is] a very important issue," one you have always considered "the hidden disease" because "you just cannot see it except that you see the effect of what it really does to people."

This is precisely why this legislation is so important.

THE BURDEN OF DIABETES AMONG SENIOR CITIZENS

Diabetes is a truly devastating disease among those Americans over age 65. Because diabetes prevalence grows with increasing age, approximately 50% of all cases of the disease occur in people over age 55. By ages 65-74, nearly 17% of the US white population, 25% of African Americans and 33% of Hispanics have diabetes. Among all Americans over age 65, approximately 19% have diabetes, although only 9% are diagnosed. These numbers will continue to increase as the growth rate of African Americans and Hispanics outpaces that of white Americans.

However, despite the fact that 9% of the Medicare population is diagnosed with diabetes, approximately 27% of the Medicare budget, or $28.6 billion, is used in treating people with diabetes. It is clear that if the prevalence of diabetes and diabetes-related complications can be reduced, substantial cost savings in Medicare can be realized. This will reduce economic burden and improve Medicare's long-term viability.

WHY **COMPREHENSIVE** DIABETES INSURANCE COVERAGE IS NECESSARY

Clearly there is a critical need for better health care coverage for this growing population. According to the Centers for Disease Control and Prevention, "Diabetes imposes a major burden of preventable illness, premature mortality, excessive financial cost and diminished quality of life, both upon persons with the disease and on the United States as a whole." Furthermore, the CDC asserts that "It is now clear that this large burden is unnecessary. Rigorous scientific studies prove that health consequences of diabetes complications -- blindness, amputations, kidney failure, and adverse outcomes of pregnancy -- can be substantially reduced by effective and widespread clinical and public health applications of preventive interventions." ***(Reducing the Burden of Diabetes, 1994,*** CDC, page 1). The attachment to my testimony further details the national burden of diabetes and its related human and economic costs.

The coverage for diabetes supplies and education embodied in your legislation, Mr. Chairman, is designed precisely to help provide the kind of "preventive interventions" called for by the CDC, and which is currently lacking for the Medicare population.

Unfortunately, diabetes care in the U.S. overall remains substandard. One need only review an analysis by a British consulting firm published in the November 1996 edition of the British magazine The *Economist*. Comparing the United States' costs and quality of care of four ailments - breast cancer, lung cancer, gallstones, and diabetes - against outcomes for the same diseases in Britain and Germany, confirms that American doctors are either on a par or surpass their counterparts in every health measure except for diabetes. The analysis finds diabetes to be the only health condition where the U.S. trails Britain and Germany by all possible indicators. The magazine went on to say "In America...by contrast...diabetics are less well-informed than British ones about their illness, less likely to take their medicine, and roughly twice as likely to suffer horrid complications as a result."

IMPROVED DIABETES CARE IS COST EFFECTIVE

By providing diabetes patients reimbursement for diabetes education and supplies, studies show we can lower the cost of providing care to those afflicted with the disease by reducing hospitalizations, visits to the emergency room and, in the longer-term, the serious complications of diabetes. Diabetes is a case where an ounce of prevention really *is* worth a pound of cure. For example:

- The State of Maine and the CDC sponsored a diabetes self-management training program in 30 hospitals and health centers, following 1,488 patients over 3 years. *Result:* A 32% reduction in hospital admissions with a savings of $293 per participant, or $3 saved for every $1 spent on diabetes self-management training.

- Maryland recently established a Diabetes Care Program for its Medicaid population to deliver a system of comprehensive and preventive care for people with diabetes. The program promotes preventive services such as outpatient diabetes education, nutrition counseling, therapeutic footwear, blood glucose monitors and supplies. An independent study found evidence that "The [Maryland] Diabetes Care Program is achieving its goals of providing integrated, continuous and accessible health care to recipients with diabetes. Our analyses show that, compared to the control group, DCP enrollees incur fewer hospitalizations, fewer emergency room visits and decreased costs."

- Merk-Medco Managed Care, which offers a specialized diabetes program, testified before Congress in 1996 that, "Providing physicians, pharmacists and patients with adequate information on diabetes management and working together to monitor patient compliance and progress can result in improved health outcomes for the patient and reduced health care costs for plan sponsors. A recent outcomes study conducted with almost 2,000 patients enrolled in our Diabetes Patient Support Program showed that hospitalizations were reduced by 21 percent; diabetes specific hospitalizations were reduced by 25 percent; diabetes-specific outpatient visits were reduced by 53 percent.

- Humana Health Care Plans and Marriott Corporation's San Antonio River Center Hotel, the chain's largest convention facility, have joined to offer a proactive diabetes management program According to Humana, the program has been

implemented at no extra cost because it will eventually reduce plan expenditures for complications of diabetes. Even in the short term, Marriott's Human Resources Director Christina Besosa is pleased with the results. "We've been able to calculate that the cost savings is right around $2,000 per associate. There is an increase in productivity and a decrease in absenteeism and tardiness," says Besosa ***(Business and Health, Successful Disease Management: Diabetes.*** 1996 page 12).

- Honeywell Corporation, with $6.7 billion in 1995 revenues and 53,000 employees has made a commitment to its workers with a program called Lifesavers. The program consists of four modules, including one for diabetes, that has produced a net return to the company of $434,000 over the past three years and enabled the company to reduce the allocation to its self-insurance fund by $1.8 million in 1995. As part of its diabetes module the company reimburses for all test strips and supplies needed for blood glucose monitoring and for two health education courses per year. ***(BAH, Successful Disease Management: Diabetes*** page 7-8).

- Comprehensive diabetes care and coverage is taking hold, but is not yet universal or consistent. According to David Lance, Vice President of Sales and Marketing for Control Diabetes Services, a diabetes management firm, "We've seen employers choose particular managed care organizations because of the comprehensive diabetes disease management programs they have in place." Lance further notes that "Managed care executives no longer see diabetes education as an additional cost, but as an added value for their clients." ***(BAH Solutions in Managed Care,*** page ***24)***

- Diabetes education has long been acknowledged as a critical component of care. According to ***Healthy People 2000,*** the national health promotion and disease prevention report prepared under the direction of the Bush Administration: "Patient education is generally considered an integral aspect of patient management and a mainstay of patient self-care. It is so widely accepted as standard diabetes management that a rigorous study design that denies education to a control group would be unethical."

- Unfortunately, access to such education is still very inconsistent. Only some 35% of people with diabetes have attended patient education classes ***(Diabetes Care,*** August 1994). According to a study published jointly by the American Association of Diabetes Educators, American Diabetes Association, The American Dietetic Association, Centers for Disease Control and Prevention and the National Diabetes Advisory Board, "Lack of reimbursement is probably the most significant impediment to the development of diabetes outpatient education programs. It is simpler to receive reimbursement for inpatient care and bury the costs of education, but it is far more expensive and far less effective."

FEDERAL ACTION

As you know, diabetes is receiving much greater attention from policymakers at the federal level. Speaker Newt Gingrich has been a strong advocate for better diabetes care for some time. He recently stated that diabetes should be among the top priorities for the House of Representatives in the 105th Congress. In laying out his agenda, Speaker Gingrich expressed support for "[moving] towards a very strong diabetes education program, because diabetes is the largest single cost in Medicare...more citizens are hurt by diabetes than any other item."

Significant bipartisan support for improved coverage of diabetes education and blood test strips exists here in the House. In the last Congress, legislation improving diabetes Medicare coverage garnered more than 250 cosponsors. Only 12 of the 4,344 bills introduced in the 104th Congress had more cosponsors than this legislation. In the new 105th Congress, the re-introduced bill, HR 58, has greater than 233 cosponsors. And HR 15 has widespread support from members of the Ways and Means and Commerce Committees.

Former Senator and Presidential candidate Bob Dole expressed support for providing better insurance coverage for diabetes supplies and education during last year's campaign.

> improved Medicare and private insurance coverage of necessary diabetes supplies and education would save lives and reduce the cost of diabetes-related illnesses to both the taxpayer and the private sector....I know and believe that anyone afflicted with diabetes, or any life-threatening, debilitating disease, needs to have the reassurance of quality, affordable, life-long health care.

The Clinton administration has also expressed support for improved diabetes Medicare coverage. In recent testimony before the Health Subcommittee of the House Commerce Committee, Dr. Bruce Vladek, Administrator of the Health Care Financing Administration (HCFA) which administers Medicare and Medicaid programs, addressed the issue of better care for diabetes. Dr. Vladek, in an exchange with Representative Elizabeth Furse, noted

> It is clear that the kinds of expanded coverage that initially came out of some of your efforts and [that of] some other folks and now seem to command such broad bipartisan support are necessary links in an effective, proactive effort to get on top of this [diabetes]. We are also talking about other things as well in addition to the quality assurance protocols, looking at payments for disease management, some of the new specialty techniques. We have to get on top of this because the human consequences are so enormous and we know what to do. Again, we believe the provisions of all the bills now reflect not a leap of faith but, in fact, just a recognition of what we know about that condition.

STATE ACTIONS

Diabetes insurance reform legislation is receiving wide-spread support throughout the nation. Many of your home state legislatures have either passed such legislation or will be considering the issue this year. Nine states have enacted laws providing insurance reimbursement for patient education and supplies. Included in the twenty-six states considering diabetes insurance reforms this legislative session are California, Connecticut, Louisiana, Nebraska, Texas, Maryland and Georgia.

Last year six states enacted diabetes insurance reform legislation. Attachment 2 lists the states which adopted such legislation and the Governors who signed them. As you can see, diabetes is a non-partisan disease. Last year's bills were signed by four Republican, one Democrat, and one Independent Governors.

Rhode Island Governor Lincoln Almond's (R) comments upon signing his state's bill are worth noting.

> Diabetics who failed to get the proper treatment often have complications that can lead to heart disease, kidney failure, blindness and limb amputations -- all of which require very costly treatment. In addition to providing diabetics with the care they deserve, this bill will help save money in the long run by avoiding many of these serious and expensive complications.

Another state which enacted legislation last year was Maine, where the State Bureau of Insurance, which studied the potential impact of the Maine legislation on the insurance industry, noted "Of the 15 insurers responding to our request for coverage information...[m]ost did not believe there would be an increase in premiums due to the proposed [legislation]."

In addition to the six states which adopted legislation last year, three others enacted such legislation earlier. One, Wisconsin, has had the time to analyze the impact of its legislation. The Wisconsin Office of the Commissioner of Insurance studied the costs of a standard benefits package for diabetes care and found that directing the private insurance community to offer a comprehensive diabetes benefit did not increase claims tiled, did not increase disbursements by the insurer, did not increase costs when compared to other benefits and did not increase premiums. (*Wisconsin* ***Commissioner*** *of Insurance,* May 1989)

One state, that recently passed diabetes insurance reform is New Mexico, where the State Corporation Commission's Insurance Department recently stated its belief, after a review of its own department's records and discussions with the managed care industry, that "the cost of implementing this legislation, projected costs on current insurance premiums, and financial impact on the insurance industry will be negligible." Their statement continued to say: "It appears to us that two results of the act are 1) more efficient use of current health care resources and 2) ultimately lower costs. We found nothing in the act which we would oppose."

CLOSING

Mr. Chairman and members of the Subcommittee, the task of reforming the Medicare program is huge. However, particularly in the case of diabetes, it is clearly a cost effective way to simultaneously improve coverage and health.

Diabetes is a serious disease. But medical research has proven that its debilitating and costly complications can be postponed or avoided. Your legislation can improve care for Medicare recipients with diabetes in our nation by empowering them to help themselves. I do not know of any chronic disease in which people who suffer from it are so responsible for its management -- day in and day out. When people with diabetes arc provided with the necessary supplies and appropriate education to manage their disease, the results will be lower overall costs and improved well being. The legislation before you today will go a long way toward meeting that important goal.

Thank you,

The Burden of Diabetes

- Diabetes is a chronic disease - there is no cure.
  - The disease affects the body's ability to produce insulin to allow blood sugar into the body as a source of energy.
  - Diabetes is the fourth leading cause of death by disease and the leading cause of new cases of blindness, kidney failure and non-traumatic lower limb amputations.
  - More than 160,000 Americans die each year from the complications resulting from diabetes.
  - About half of all diabetes cases occur after age 55.
- The number of people with diabetes is reaching epidemic proportions:
  - The disease has tripled since 1960.
  - In 1992, there were 14 million Americans with diabetes; there are now 16 million
  - In 1992, the nation spent $92 billion on direct and indirect costs of diabetes care. According to the National Institutes of Health, the nation now spends $138 billion a year on diabetes and related complications. That is an incredible increase of 50% in just five years.
- The diabetes burden on seniors:
  - 50% of those afflicted are over the age of 55.
  - Approximately 19% of those Americans over the age of 65 have diabetes, though only 9% are diagnosed.
  - While 9% of the Medicare population is diagnosed with diabetes, approximately 27%, or $28.6 billion, of the annual Medicare budget is used in treating people with diabetes.
  - Many seniors are at increased risk of undiagnosed diabetes because of the risk factors of age, obesity and sedentary lifestyle.
  - Diabetes is the root cause of hospitalizations for those who do not know they have the disease.
- It is important to make progress on this issue:
  - Diabetes is silent: of the sixteen million Americans that have it, half do not know it.
  - Diabetes is serious: diabetes leads to major health problems if it remains undetected.
- Only preventive treatment can improve the quality of life for diabetes patients at substantially reduced health care costs. According to the December 1995 issue of Practical *Diabetology,* it is estimated that through better treatment and management of diabetes:
  - The incidence of diabetes-related blindness could be reduced by 90%.
  - Diabetes-related kidney disease requiring dialysis could be reduced by 50%
  - Diabetes-related complications and amputations could be reduced by 50%.

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EXPERIENCE:

1980 to Present — **American Diabetes Association**
Current Chair of the National Board of Directors,
sewing on a full-time basis
Previous positions;
Chair-Elect and Vice Chair of the National Board of Directors
Chair of various national committees
Chair of the Board of the New York Downstate Affiliate
Chair *of* me Board of the New York City Chapter

1994 to 1996 — United Baseball **League, L.L.C.**
Chief Financial Officer and Initial investor of newly formed baseball league

1992 to 1995 — Seaport **Capital inc.**
Co-founder and principal of merchant banking firm.

1982 to 1991 — Prudential Securities **Incorporated**

1987 to 1991 — executive Vice President, in charge of the Merchant Banking:
Member of Exec. Comm., Bd. of Directors, & Investment Banking Mgmt. Comm.
Chairman and CEO of Prudential-Bache Interfunding Inc.
Chairman of Prudential-Bache Partners **Inc.**
Board Member of Prudential Asia Investments and Prudential Global Funding

1962 to 1987 — Senior Vice President in Charge of Corporate Development:
Responsible for corporate planning and internal consulting; acquisition **analysis; marketing** research; new product analysis; and liaison with Me parent company.

1970 to1982 — The **Prudential** Insurance **Comcanv of America**

1962 — Vice President *in* **charge** of Prudential/Bache Liaison Unit

1970 to 1961 — Various positions in the Corporate Finance Department of Prudential's Investment Area: private placement lending and leverage buyout investing

EDUCATION; — B.A., 1968, Economics, Cornell University
M.B.A., 1970, Finance, Wharton School of Finance and Commerce
University of Pennsylvania

PROFESSIONAL DESIGNATION: — Beta Gamma Sigma (Academic Honor Society)
C. F.A. (Chartered Financial Analyst)
NASD Pnncipal (Series 24)

OTHER ACTIVITIES: — National Center for Learning Disabilities
Currently Treasurer and Board Member
New York Foundation
Member of Board of Trustees